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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION

DENISE WILLIAMS,	}	Case No. ED CV 13-1657-DFM
Plaintiff,		
v.		MEMORANDUM OPINION AND
CAROLYN W. COLVIN, Acting		ORDER
Commissioner of Social Security,		
Defendant.	}	

Plaintiff Denise Williams (“Plaintiff”) appeals the denial of her applications for Social Security disability benefits. The Court concludes that the ALJ did not provide specific and legitimate reasons adequately supported by substantial evidence for rejecting the opinion of Plaintiff’s treating psychiatrist. The ALJ’s decision is therefore reversed and the matter is remanded for further proceedings consistent with this opinion.

I.

FACTUAL AND PROCEDURAL BACKGROUND

This is Plaintiff’s second attempt to secure Social Security disability benefits; a prior set of applications were denied by an ALJ on September 26, 2007. Administrative Record (“AR”) 13. Plaintiff filed the present applications

1 for Disability Insurance and Supplemental Security Income benefits on July
2 13, 2010, alleging disability beginning March 13, 2009. *Id.* After a hearing, the
3 ALJ found that Plaintiff had severe impairments of affective disorder, obesity,
4 and sickle cell anemia. AR 16. After finding that Plaintiff retained the residual
5 functional capacity (“RFC”) to perform light work with some additional
6 limitations to accommodate for her mental impairment, the ALJ concluded
7 that Plaintiff was not disabled because there was work available in significant
8 numbers in the national and regional economies that she could perform. AR
9 17-22.

10 II.

11 ISSUES PRESENTED

12 The parties dispute whether the ALJ erred in assessing (1) the opinion of
13 Plaintiff’s treating psychiatrist, (2) Plaintiff’s credibility, and (3) the statements
14 of her mother and daughter.¹ *See* Joint Stipulation (“JS”) at 4.

15 III.

16 STANDARD OF REVIEW

17 Under 42 U.S.C. § 405(g), a district court may review the
18 Commissioner’s decision to deny benefits. The ALJ’s findings and decision
19 should be upheld if they are free from legal error and are supported by
20 substantial evidence based on the record as a whole. 42 U.S.C. § 405(g);
21 *Richardson v. Perales*, 402 U.S. 389, 401 (1971); *Parra v. Astrue*, 481 F.3d
22 742, 746 (9th Cir. 2007). Substantial evidence means such relevant evidence as
23 a reasonable person might accept as adequate to support a conclusion.

24 ¹ Because the Court concludes that the ALJ failed to provide specific and
25 legitimate reasons for rejecting the opinion of Plaintiff’s treating psychiatrist,
26 the Court does not reach the other issues and will not decide whether either
27 would independently warrant relief. Upon remand, the ALJ may wish to
28 consider Plaintiff’s other claims of error.

1 Richardson, 402 U.S. at 401; Lingenfelter v. Astrue, 504 F.3d 1028, 1035 (9th
 2 Cir. 2007). It is more than a scintilla, but less than a preponderance.
 3 Lingenfelter, 504 F.3d at 1035 (citing Robbins v. Soc. Sec. Admin., 466 F.3d
 4 880, 882 (9th Cir. 2006)). To determine whether substantial evidence supports
 5 a finding, the reviewing court “must review the administrative record as a
 6 whole, weighing both the evidence that supports and the evidence that detracts
 7 from the Commissioner’s conclusion.” Reddick v. Chater, 157 F.3d 715, 720
 8 (9th Cir. 1996). “If the evidence can reasonably support either affirming or
 9 reversing,” the reviewing court “may not substitute its judgment” for that of
 10 the Commissioner. Id. at 720-21.

11 IV.

12 THE ALJ ERRED IN REJECTING THE OPINION OF PLAINTIFF’S 13 TREATING PHYSICIAN

14 Plaintiff contends that the ALJ failed to provide specific and legitimate
 15 reasons supported by substantial evidence for not giving controlling weight to
 16 the opinion of Plaintiff’s treating psychiatrist as expressed in forms completed
 17 in April 2011 and February 2012. JS at 4-5.

18 A. Background

19 Plaintiff first sought treatment at the Victor Valley Behavioral Health
 20 Center in either early 2005 or late 2006. See AR 393, 395, 421. She returned to
 21 the clinic a few times in 2009. See AR 247-59. When she again returned in
 22 April 2010, she began to be treated by Dr. Dennis Payne, see AR 241-44, who
 23 continued to treat her through at least May 2013. See AR 413-14, 428; see
 24 generally AR 233-42, 308-17, 349-75, 377-87, 404, 406-11, 413-14.

25 On April 28, 2011, Dr. Payne completed a form in which he marked
 26 boxes indicating that Plaintiff had “[n]o useful ability to function” with respect
 27 to all but a handful of work-related abilities, such as “sustain an ordinary
 28 routine without special supervision,” “make simple work-related decisions,”

1 and “accept instructions and respond appropriately to criticism from
2 supervisors.” AR 377-78. He noted that Plaintiff suffered from auditory and
3 visual hallucinations and mood swings, broke things out of anger, and could be
4 violent in the workplace. AR 378. He opined that Plaintiff would miss more
5 than four days of work per month. Id.

6 On February 7, 2012, Dr. Payne wrote to the Social Security
7 administration, noting that Plaintiff had been under his care for years, was
8 “unable to work . . . in any employment setting,” and would “most likely
9 deteriorate.” AR 395. He did not indicate any basis for this opinion in the
10 letter. Id. That same day, Dr. Payne completed a form in which he indicated
11 that Plaintiff’s ability to carry on basic workplace activities – such as carrying
12 out simple and complex instructions, maintaining concentration, adhering to a
13 schedule, and responding appropriately to changes in work setting – was poor.
14 AR 394. He opined that Plaintiff would not be able to complete a normal
15 workday and workweek without interruptions from psychological symptoms.
16 Id.

17 On June 25, 2013, Dr. Payne wrote to the Appeals Council, noting that
18 Plaintiff continued to receive treatment for schizoaffective disorder, had a
19 Global Assessment Functioning (“GAF”) score of 45,² was “unable to work,”
20 and would “most likely rapidly deteriorate in any work setting in the next

21 ² A GAF score of 41 to 50 indicates serious symptoms or a serious
22 impairment in social or occupational functioning. See Diagnostic and
23 Statistical Manual of Mental Disorders 34 (revised 4th ed. 2000). The
24 Commissioner has declined to endorse GAF scores, 65 Fed. Reg. 50764-65
25 (Aug. 21, 2000) (GAF score “does not have a direct correlation to the severity
26 requirements in our mental disorders listings”), and the most recent edition of
27 the DSM “dropped” the GAF scale, citing its lack of conceptual clarity and
28 questionable psychological measurements in practice. Diagnostic and
Statistical Manual of Mental Disorders 16 (5th ed. 2012).

1 twelve months.” AR 428.

2 The ALJ found that Plaintiff had the severe impairment of affective
3 disorder. AR 16. After finding that Plaintiff’s impairment did not meet or equal
4 Listing 12.04, the ALJ concluded that Plaintiff has the residual functional
5 capacity (“RFC”) to perform light work if she was further limited to “non-
6 public, simple, routine, repetitive tasks” with “only occasional contact with
7 coworkers and supervisors.” AR 17. In reaching this conclusion, the ALJ
8 addressed Dr. Payne’s opinion as follows:

9 [T]he undersigned has considered, but does not give
10 considerable weight to, the opinion of the treating source, Dr.
11 Dennis Payne In this case, the opinion of this treating source
12 is not given controlling weight because the psychiatrist does not
13 document significant positive objective clinical or diagnostic
14 findings to support the assessed functional limitations and because
15 these extreme functional limitations are inconsistent with the
16 record as a whole. . . . [¶] Dr. Payne did not document positive
17 objective clinical or diagnostic findings to support his functional
18 assessment. Dr. Payne’s opinion is not given great weight because,
19 despite the length of time he treated the claimant, his assessment
20 of functional limitations is not supported with objective evidence
21 and his assessment is not consistent with his own treatment
22 records or the record as a whole.

23 AR 20.

24 In contrast, the ALJ gave “great weight” to a December 2010 opinion of
25 Dr. S. Khan, a state-agency consulting examiner. Id.; see AR 320-36. The ALJ
26 noted that Dr. Khan “concluded the claimant should be limited to simple
27 repetitive tasks.” Id. The ALJ found “nothing of record to contradict [Dr.
28 Khan’s] opinion” with respect to Plaintiff’s RFC and that Dr. Khan’s

1 assessment was “reasonable and consistent with the objective medical
2 evidence.” Id.

3 **B. Applicable Law**

4 Three types of physicians may offer opinions in Social Security cases:
5 those who directly treated the plaintiff, those who examined but did not treat
6 the plaintiff, and those who did not treat or examine the plaintiff. See 20
7 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2); Lester v. Chater, 81 F.3d 821, 830 (9th
8 Cir. 1996). A treating physician’s opinion is generally entitled to more weight
9 than that of an examining physician, which is generally entitled to more weight
10 than that of a non-examining physician. Lester, 81 F.3d at 830. Thus, when a
11 treating doctor’s opinion is not contradicted by another doctor, it may be
12 rejected only for clear and convincing reasons. Id. When a treating doctor’s
13 opinion is contradicted by another doctor, the ALJ must provide specific,
14 legitimate reasons based on substantial evidence in the record for rejecting the
15 treating doctor’s opinion. Orn v. Astrue, 495 F.3d 625, 632 (9th Cir. 2007);
16 Lester, 81 F.3d at 830-31. However, “[t]he opinion of a non-examining
17 physician cannot by itself constitute substantial evidence that justifies the
18 rejection of the opinion of either an examining physician or a treating
19 physician”; such an opinion may serve as substantial evidence only when it is
20 consistent with and supported by other independent evidence in the record. Id.
21 at 831; see Morgan v. Comm’r of the Soc. Sec. Admin., 169 F.3d 595, 600 (9th
22 Cir. 1999). However, “[t]he ALJ need not accept the opinion of any physician,
23 including a treating physician, if that opinion is brief, conclusory, and
24 inadequately supported by clinical findings.” Thomas v. Barnhart, 278 F.3d
25 947, 957 (9th Cir. 2002); accord Tonapetyan v. Halter, 242 F.3d 1144, 1149
26 (9th Cir. 2001).

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1 **C. Analysis**

2 As detailed above, the ALJ offered two reasons for rejecting Dr. Payne's
3 opinion. First, the ALJ found that Dr. Payne's opinion was "not supported by
4 objective evidence," noting Dr. Payne's failure to "document significant
5 positive objective clinical or diagnostic findings to support the assessed
6 functional limitations." AR 20. Second, the ALJ found that Dr. Payne's
7 opinion was "not consistent with his own treatment records or the record as a
8 whole." Id.

9 Although an ALJ may discredit a treating physician's opinion where that
10 opinion is unsupported by objective medical findings, see Batson v. Comm'r of
11 Soc. Sec. Admin., 359 F.3d 1190, 1195 (9th Cir. 2004), the ALJ's rejection of
12 Dr. Payne's opinion as inadequately supported by objective evidence was
13 legally insufficient. Psychiatric impairments are not as amenable to
14 substantiation by objective laboratory testing as are physical impairments.
15 Hartman v. Bowen, 636 F. Supp. 129, 131-32 (N.D. Cal. 1986); see also Heller
16 v. Doe by Doe, 509 U.S. 312, 322 (1993) (noting that "diagnosis of mental
17 illness is difficult"). The diagnostic techniques necessarily will be less tangible,
18 Lebus v. Harris, 526 F. Supp. 56, 60 (N.D. Cal. 1981), and mental disorders
19 cannot be "ascertained and verified" like physical ailments, Hartman, 636 F.
20 Supp. at 132. Thus, in the case of mental illness, clinical and laboratory data
21 may consist of "the diagnoses and observations of professional psychiatrists
22 and psychologists." Id.; see also Bilby v. Schweiker, 762 F.2d 716, 719 (9th
23 Cir. 1985) (reversing ALJ's decision to disregard psychiatrists' opinions and
24 emphasizing that "[d]isability may be proved by medically-acceptable clinical
25 diagnoses, as well as by objective laboratory findings" (internal quotation
26 marks omitted)); Yang v. Astrue, No. 06-2658, 2008 WL 802321, at *5 (E.D.
27 Cal. Mar. 25, 2008). Indeed, the Commissioner's own regulations recognize
28 the validity of clinical findings in mental-status examinations. See 20 C.F.R.

1 § 404.1513(b)(2).

2 Here, Dr. Payne's diagnoses and opinion were based on his treatment
3 and observations of Plaintiff for more than three years. The record shows that,
4 in addition to Dr. Payne's regular visits with Plaintiff, Dr. Payne and his
5 colleagues occasionally performed fuller assessments of her functioning, see
6 AR 241-46, 255-59. The ALJ did not explain how Dr. Payne's regular,
7 personal observations of Plaintiff over a three-year period and his April 28,
8 2011 and February 7, 2012 evaluations do not constitute evidence of "objective
9 clinical or diagnostic findings."

10 In fact, there is significant evidence of observations made by Dr. Payne
11 to support his opinions. For example, Dr. Payne's February 2012 finding that
12 Plaintiff could not complete a normal workweek without interruptions from
13 psychological symptoms is consistent with (1) his repeated observation that she
14 was hearing voices, AR 238, 239, 240, 312, 349, 353, 354, 355, 363, 367, 370,
15 371; and (2) his repeated observation that she was having visual hallucinations
16 such as seeing shadows, AR 235, 238, 240, 357, 363, 370, 397. Likewise, Dr.
17 Payne's April 2011 findings that Plaintiff could not get along with co-workers
18 or peers without exhibiting behavioral extremes and could be violent in the
19 workplace is consistent with (1) his observation in September 2010 that she
20 became so upset that 911 had to be called, AR 311; (2) his notation in April
21 2011 that she had punched a window with her fist, AR 363; (3) his notation in
22 November 2010 about an episode where Plaintiff had to be hospitalized after
23 threatening her 16 year-old son, AR 373. Finally, Dr. Payne's finding that
24 Plaintiff was not able to maintain concentration, attention, and persistence is
25 consistent with his observations that (1) she was severely distracted, AR 397;
26 (2) her memory was impaired, id.; and (3) she reported being "confused," AR
27 355.

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1 Turning to the ALJ's second basis for rejecting Dr. Payne's opinion, the
2 Court finds that although an ALJ may reject a treating physician's opinion
3 when that opinion is inconsistent with the physician's treatment reports, see
4 Rollins v. Massanari, 261 F.3d 853, 856 (9th Cir. 2001), the record does not
5 support the ALJ's finding that Dr. Payne's opinion was not supported by his
6 treatment notes. If anything, as the citations in the preceding paragraph
7 demonstrate, Dr. Payne's treatment notes are consistent with his finding that
8 Plaintiff was not capable of working.

9 Opinions of treating physicians are generally given more weight than the
10 opinions of other physicians because treating physicians "are likely to be the
11 medical professionals most able to provide a detailed, longitudinal picture of
12 [the claimant's] medical impairment(s) and may bring a unique perspective to
13 the medical evidence that cannot be obtained from the objective medical
14 findings alone or from reports of individual examinations, such as consultative
15 examinations or brief hospitalizations." 20 C.F.R. §§ 404.1527(c)(2),
16 416.927(c)(2). Based on the length of the treatment relationship and Dr.
17 Payne's experience with Plaintiff, Dr. Payne had the broadest range of
18 knowledge regarding Plaintiff's mental condition, which knowledge is
19 supported by the treatment records. See id.; see also Lester, 81 F.3d at 833
20 ("The treating physician's continuing relationship with the claimant makes
21 him especially qualified . . . to form an overall conclusion as to functional
22 capacities and limitations, as well as to prescribe or approve the overall course
23 of treatment."). By concluding that there was little, if any, evidence of
24 "objective clinical or diagnostic findings" in Dr. Payne's treating records, the
25 ALJ ignored evidence in the record and also failed to consider the unique
26 nature of Dr. Payne's treatment relationship with Plaintiff. See Reddick, 157
27 F.3d at 722-23 (finding that it is impermissible for the ALJ to develop an
28 evidentiary basis by "not fully accounting for the context of materials or all

1 parts of the testimony and reports”); Sprague v. Bowen, 812 F.2d 1226, 1230
2 (9th Cir. 1987) (“The rationale for giving greater weight to a treating
3 physician’s opinion is that he is employed to cure and has a greater
4 opportunity to know and observe the patient as an individual.”); Embrey v.
5 Bowen, 849 F.2d 418, 422 (9th Cir. 1988) (“The subjective judgments of
6 treating physicians are important, and properly play a part in their medical
7 evaluations.”).

8 Because the record, including Dr. Payne’s treatment notes, provides
9 substantial evidence consistent with the doctor’s opinion that Plaintiff is
10 incapable of work, the Court concludes that the ALJ’s finding to the contrary
11 was legal error. Moreover, the ALJ’s finding that Dr. Payne’s opinion was
12 inadequately supported by objective diagnostic or clinical evidence ignores the
13 importance of his subjective assessments of Plaintiff on a relatively regular
14 basis over the course of years.

15 Further, having rejected Dr. Payne’s opinion, the ALJ relied upon the
16 2010 opinion of a state-agency doctor who had never examined Plaintiff, let
17 alone made any diagnostic or clinical findings of his own. Even if the ALJ
18 correctly found that Dr. Khan’s opinion was “reasonable and consistent with
19 the objective medical evidence,” and thus constituted substantial evidence of
20 Plaintiff’s mental-health status at that time, Tonapetyan, 242 F.3d at 1149,
21 Dr. Khan’s review included only records up to and including Plaintiff’s
22 November 16, 2010 appointment. See AR 335-36. Dr. Khan therefore did not
23 know and could not opine about the fact that Plaintiff continued to suffer
24 serious symptoms such as hallucinations and violent outbursts throughout
25 2011 and early 2012, despite regular visits with Dr. Payne and greater
26 compliance with her prescriptions. See, e.g., AR 349, 353, 354, 355, 357, 363,
27 367, 370, 371, 397.

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1 Thus, to the extent that the ALJ relied solely on Dr. Khan's opinion in
2 assessing Plaintiff's symptoms through early 2012, that was error. See Calkins
3 v. Astrue, No. 08-2385, 2010 WL 1286741, at *3 (E.D. Cal. Mar. 29, 2010)
4 (error to reject treating doctor's later opinion in favor of opinions of state-
5 agency physicians, who had no opportunity to review records evidencing
6 Plaintiff's deteriorating psychiatric condition). Having rejected the sole medical
7 opinion relating to Plaintiff's mental health after November 2010, it was
8 incumbent upon the ALJ to seek additional medical opinion evidence to
9 enable proper evaluation of Plaintiff's mental impairments. See Tonapetyan,
10 242 F.3d at 1150 (explaining that when "record is inadequate to allow for
11 proper evaluation of evidence," ALJ has duty to develop record); Delorme v.
12 Sullivan, 924 F.2d 841, 849 (9th Cir. 1991) (noting that duty is "especially
13 important" when plaintiff suffers from a mental impairment); cf. Sivilay v.
14 Comm'r of Soc. Sec., 32 F. App'x 911, 914-15 (9th Cir. 2002) (remanding for
15 further medical opinion evidence appropriate when ALJ's rejection of
16 statements from claimant, her husband, and her treating psychiatrist left
17 "record that did not offer especially firm ground for a decision"). In finding
18 Plaintiff "functional" and attributing her severe symptoms merely to her
19 having run out of medication, AR 19, the ALJ appears instead to have
20 improperly substituted his own judgment for that of the medical professionals.
21 See Miller v. Astrue, 695 F. Supp. 2d 1042, 1048 (C.D. Cal. 2010); Rohan v.
22 Chater, 98 F.3d 966, 970-71 (7th Cir. 1996).

23 **D. A Remand for Further Proceedings Is Appropriate**

24 Where, as here, the Court finds that the ALJ improperly discredited
25 medical testimony, the Court has discretion as to whether to remand for
26 further proceedings. See Harman v. Apfel, 211 F.3d 1172, 1175-78 (9th Cir.
27 2000). Where no useful purpose would be served by further administrative
28 proceedings, or where the record has been fully developed, it is appropriate to

1 exercise this discretion to direct an immediate award of benefits. Id. at 1179
2 (noting that “the decision of whether to remand for further proceedings turns
3 upon the likely utility of such proceedings”); see also Garrison v. Colvin, ---
4 F.3d ---, 2014 WL 3397218, at *20-*21 (9th Cir. July 14, 2014) (noting that this
5 doctrine applies to medical opinion testimony).

6 A remand is appropriate, however, where there are outstanding issues
7 that must be resolved before a determination of disability can be made and it is
8 not clear from the record that the ALJ would be required to find the claimant
9 disabled if all the evidence were properly evaluated. Bunnell v. Barnhart, 336
10 F.3d 1112, 1115-16 (9th Cir. 2003); see also Connett v. Barnhart, 340 F.3d 871,
11 876 (9th Cir. 2003). Here, remand is appropriate for the ALJ to fully and
12 properly consider the opinion of Plaintiff’s treating physician, solicit further
13 medical opinion evidence, if necessary, and determine whether the medical
14 opinion evidence supports a finding of disability.

15 **V.**

16 **CONCLUSION**

17 For the reasons stated above, the decision of the Social Security
18 Commissioner is REVERSED and the action is REMANDED for further
19 proceedings consistent with this opinion.

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21 Dated: August 25, 2014

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24 DOUGLAS F. McCORMICK
25 United States Magistrate Judge
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